

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005846	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/05/2012
NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7833 W JEFFERSON BLVD FORT WAYNE, IN 46804		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00114166.</p> <p>Complaint IN00114166 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: September 5, 2012</p> <p>Facility number: 005846 Provider number: 005846 AIM number: N/A</p> <p>Survey team: Sue Brooker RD TC Rick Blain RN Diane Nilson RN</p> <p>Census bed type: Residential: 73 Total: 73</p> <p>Census payor type: Other: 73 Total: 73</p> <p>Sample: 4</p> <p>Coventry Meadows Assisted Living was found to be in compliance 410 IAC 16.2 in regard to the Investigation of Complaint IN00114166.</p> <p>Quality review 9/07/12 by Suzanne Williams, RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

QE1P11

If continuation sheet 1 of 1